## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445427	B. WING			10/07/2021		
NAME OF PROVIDER OR SUPPLIER  AHC BETHESDA				STREET ADDRESS, CITY, STATE, ZIP CODE  444 ONE ELEVEN PLACE  COOKEVILLE, TN 38501				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE	
F 000	was conducted by the October 6, 2021. The Compliance with 42 regulations and has Centers for Disease (CDC) recommend COVID-19. Total centers for Disease (CDC) recommend COVID-19.	sed Infection Control Survey the STATE AGENCY on he facility was found to be in CFR §483.80 infection control s implemented the CMS and e Control and Prevention ed practice s to prepare for		TITLE			(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		445427	B. WING			10/07/2021	
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E 000	Survey was conduction October 6, 2021	sed Emergency Preparedness of the STATE AGENCY. The facility was found to be 42 CFR §483.73 related to	E	000	DEFICIENCY)		
ADODATOS	DIDECTORIC OF PROCESS	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITI F		(X6) DATE

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FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ B. WING 10/07/2021 TN7105 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 444 ONE ELEVEN PLACE AHC BETHESDA COOKEVILLE, TN 38501 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 000 N 000 Initial Comments A COVID-19 Focused Infection Control Survey was conducted by the STATE AGENCY on October 6, 2021. The facility was found to be in compliance with Chapter 1200-8-6, Standards for Nursing Homes regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 67.

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE